MENTAL HEALTH AND DISABILITY SERVICES COMMISSION
March 20, 2014, 9:30 am to noon
United Way Conference Center, Room F
1111 9th Street, Des Moines, IA
MEETING MINUTES

MHDS COMMISSION MEMBERS PRESENT:

Neil Broderick
Richard Crouch
Lynn Grobe
Chris Hoffman
David Hudson (by phone)
Betty King (by phone)
Sharon Lambert
Brett McLain (by phone)
Rebecca Peterson
Deb Schildroth
Patrick Schmitz
Marilyn Seemann
Suzanne Watson
Jack Willey

MHDS COMMISSION MEMBERS ABSENT:

Jill Davisson
Senator Joni Ernst
Senator Jack Hatch
Representative Dave Heaton
Representative Lisa Heddens
Susan Koch-Seehase

OTHER ATTENDEES:

Tammie Amsbaugh	U of I, Center for Disabilities and Development
Theresa Armstrong	MHDS, Bureau Chief Community Services & Planning
Cheryl Boles	Warren County MH/DD Services
Teresa Bomhoff	Iowa Mental Health Planning Council/NAMI Greater DM
Kyle Carlson	Magellan Health Services
Diane Diamond	DHS, Targeted Case Management
Eric Donot (phone)	Advocate
Jacob Dornbush	Pathways Behavioral Services
George Eichhorn	ChildServe
Connie Fanselow	MHDS, Community Services & Planning
Jim Friberg	Department of Inspections and Appeals
Melissa Havig	Magellan Health Services
Jane Hudson	Disability Rights Iowa
Karen Hyatt	MHDS, Community Services & Planning
June Klein (phone)	Brain Injury Alliance of Iowa
Jim Rixner	Siouxland Mental Health Center
Renee Schulte	DHS Consultant
Ryanne Wood (phone)	Lee County

WELCOME AND CALL TO ORDER

Jack Willey called the meeting to order at 9:35 a.m., welcomed attendees, and led introductions. No conflicts of interest were identified for today's meeting. Quorum was established, with eleven members present and three participating by phone.

APPROVAL OF MINUTES

Deb Schildroth made a motion to approve the minutes of the February 20, 2014 meeting as presented. Patrick Schmitz seconded the motion. The motion passed unanimously with Chris Hudson, Betty King, and Brett McLain participating in the vote by phone.

NOMINATING COMMITTEE

Jack Willey announced the appointment of a Nominating Committee to put forward candidates for Chair and Vice-Chair for the 2014-2015 year. Election of Officers will take place at the April meeting, and the newly elected Chair and Vice-Chair will begin their terms on May 1. Jack appointed Deb Schildroth to chair the Nominating Committee, and Rebecca Peterson and Richard Crouch as committee members.

DHS/MHDS UPDATE

Theresa Armstrong noted that Rick Shults had planned to be at the meeting this morning, but was just called to the Capital for legislative meetings and will try to make it back here later. Theresa presented the DHS/MHDS update, beginning with bills in the Iowa Legislature:

HF 2379 – This bill authorizes DHS to accredit crisis stabilization programs and clarifies that such programs will not be required to meet Department of Inspections and Appeals (DIA) standards for accreditation that apply to other types of health care facilities. This legislation follows up on the pilot program that began two years ago and allows it to move forward. It has now passed both the House and the Senate.

HF 2417 – This is a "clean up" (or Code Editor) bill for making necessary technical corrections to the Iowa Code. The changes update old language relating to the county CPC process to be relevant to the new regional administration system and revises language where needed to make it consistent with new processes and updates that have been made elsewhere in Code. This bill has passed the House and passed out of Senate Committee. There are likely to be some amendments made to it in the Senate.

HSB 637 – This bill makes changes to the requirement that counties designated their community mental health centers or requested waivers; it will now say that providers must be approved according to Chapter 230A, which lays out requirements for the operation of community mental health centers.

HF 2378 – This bill was initiated by the Iowa Association of Psychologists. It gives the state board authority to grant provisional licenses to psychologists who have completed their Doctorate to practice independently for two years before becoming fully licensed. Currently they can only practice under supervision of another licensed psychologist for the first two years.

SF 2320 – This bill relates to Consumer Directed Attendant Care (CDAC), which is a Medicaid program option that allows an individual to self-direct their personal care services. DHS had put some rules forward that would have prohibited family members from providing CDAC services and withdrew them when a significant number of families indicated that would present problems for them. Legislators chose to act by introducing this bill, which would allow family members to continue to be care providers. The bill has passed the Senate and is up for debate in the House. The concern that gave rise to the proposed change in Medicaid rules is that it can be difficult to draw the line between parent or family member and paid caregiver when one person is in both roles.

SF 2330 – This bill relates to how community mental health centers are reimbursed. CMHCs and Magellan worked together on the bill. Currently the CMHCs are reimbursed throughout the year, but do cost reporting at the end of the year. The cost reporting delays the collection of a significant amount of the costs for a period of 12 to 24 months. Under this bill, CMHCs can choose to continue cost reporting or go to a fee-based reimbursement model that will eliminate the delay. It has passed the Senate and passed out of committee in the House, so it will still be up for debate in the House.

SF 2296 – This bill relates to 812 commitments, which are for people who have committed crimes and are found to be mentally incompetent to stand trial. The number of this type of commitments each year is very small. This bill specifies who is responsible for paying for the related services. Under this bill, those who are considered dangerous are ordered to the Department of Corrections; those who are not considered dangerous would be the responsibility of DHS and would be mandated to one of the state mental health facilities. This bill has passed the Senate and the House.

SF 2211 – This bill defines who is considered a sexually violent predator. It allows violent juvenile offenses to be including in making the determination. Individuals determined to be sexually violent predators would be admitted to the CCUSO (Civil Commitment Unit for Sexual Offenders) at the Cherokee MHI.

Theresa noted that work is being done in committee on the Health and Human Services Appropriations bill; it is likely the last of the bills passed before the end of the legislative session.

Chris Hoffman asked how the change in Iowa's FMAP (Federal Medical Assistance Percentage) would affect the Human Services appropriation. Theresa responded that it will have an impact, but she does not yet have specific information. Iowa's economy is comparatively stronger than many other states, which means that the state is expected

to a larger share of the costs of the Medicaid program. The FMAP applies to traditional Medicaid, but not to the Medicaid expansion population.

Regional Updates – DHS has received twelve 28E Agreements from regions. Fourteen regions will have to complete 28E Agreements; Polk County will not since it is operating as a single-county region. The two remaining 28E Agreements are expected to be submitted soon. Three of the agreements have been completely approved by DHS, and several more are close to final approval. Nine needed some revisions; all nine of those regions have had communications with DHS about the revisions, and four or five have been revised and resubmitted. Regional Management Plans are due April 1. The first one was submitted just this week. Management plans include the regional budget, and lay out specific services, providers, and local access points for the region.

Deb Schildroth commented that regional governing boards could file their 28E Agreement with the Secretary of State and proceed with doing business under it pending the DHS approval of the agreement. Theresa Armstrong noted that since the 28E agreements are not due until July 1, yet management plans are due April 1, and the management plans were supposed to be approved by the governing board, regions have had to change the order of some things in their own timelines to make it work.

Jack Willey asked other members how their regions are selecting provider and family member representatives to their governing boards. Suzanne responded that her region set up three of different local area advisory council meetings that are open for anyone who wants to attend. The people who came to those meetings were asked to vote on 12 representatives to form the official advisory body. The advisory body will then select two members to represent them on the governing board. Deb Schildroth said her region has local advisory boards in place and they each selected two representatives (provider and family member) to the regional advisory board. The regional advisory board then appointed two members who joined the governing board in January. They participate as members and can make motions, but do not have a vote on the governing board.

Iowa Health and Wellness Plan – Theresa Armstrong reported on the enrollment numbers for the IHAWP as of March 6:

- Total number of enrollees is 74,552
- 59,927 are enrolled in the Iowa Wellness Plan (0 to 100% FPL)
- 14,625 are enrolled in the Marketplace Choice Plan (100 to 138% FPL); these individuals have coverage through Coventry or Co-opportunity
- 3219 of the enrollees have been determined to be medically exempt thus far
- Actuaries estimated that the medically exempt numbers would be about 14% of the total
- Since the medically exempt determination takes some time after initial enrollment, those numbers will change as more people are identified
- The overall numbers are growing by 800 to 1000 new enrollees per day

Chris Hoffman commented that it would be valuable to him as a provider to know how many people enrolling in the Marketplace Choice group are choosing the Coventry plan

and how many are choosing the Co-opportunity plan. He asked if there are any estimates about now many more people could potentially be enrolled. Theresa responded that the early estimates were for about 150,000 new enrollees total; if that estimate is accurate, Iowa is about halfway there in terms of enrollment numbers.

Administrative Rules – The Autism Support Program rules passed by the Commission were also approved by the Administrative Rules Review Committee (ARRC) with very few questions. The rules go into effect April 1. Magellan Health Services was the successful bidder to the RFP. DHS has worked with them to get the information out and they will be ready to accept the first applications on April 1. Melissa Havig commented that Magellan expects to receive a large number of applications initially. Theresa noted that there is $2 million in funding for this this fiscal year, and there is funding included in the Governor's budget for the next fiscal year.

CRISIS STABILIZATION RULE DEVELOPMENT

Renee Schulte and the members of the Crisis Stabilization Rules Committee presented an update on development of the administrative rules for Crisis Stabilization services. Jack Willey reported that the committee met on April 3rd and again yesterday, on April 16th. The members of the committee are Jack Willey, Susan Koch-Seehase, Patrick Schmitz, Neil Broderick, Rebecca Peterson, Chris Hoffman, and Suzanne Watson. Theresa Armstrong, Renee Schulte, Karen Hyatt, and Connie Fanselow have also been participating in the meetings. The work is continuing. Initially they had hoped to have a draft ready to vote on at the April meeting; it is more likely that the rules will not be ready to notice until May because they have to go through a series of reviews before they reach that stage. So far, they have made a first review of the eight crisis stabilization services identified in legislation. The group still needs to review definitions, and do further work in determining the components, standards, and requirements for each of the services.

Patrick Schmitz noted that they have looked at work on developing crisis services that was done here in Iowa five or six years ago, looked at what other states are currently doing, and are now trying to sort out what will work best, with enough flexibility to fit both rural and urban areas of Iowa. He said it is a challenge to make it all flow into a coherent and coordinated system. Jack said that everyone on the group comes to it from a different perspective, which is helpful, and they are trying to come up with a system that will allow regions and providers to make it work well for the people who need to access the services.

Patrick said the group has discussed the importance of including peers as much as possible and noted that some of the state examples they have reviewed do not have a strong peer component. Suzanne Watson said they are looking at crisis stabilization as a continuum of care that needs to be open enough so that it can be done in a variety of ways that work for the communities in different areas of the state.

Renee Schulte noted that these rules will provide for all eight crisis services that were identified in core services and additional ("core plus") services, and services that are facility-based as well as those that are community-based. The eight crisis stabilization services included are:

1. 24-hour crisis response
2. Evaluation
3. Personal emergency response system
4. 24-hour crisis hotline
5. Mobile response (including EMS rural options)
6. 23-hour crisis observation and holding
7. Crisis stabilization facility-based and community-based services
8. Crisis residential services

Renee said the challenge is how to define these services in a way that they all work together as a continuum. She noted that the committee wants to be as flexible as possible, yet these rules will create the accreditation standards for the services, and Medicaid rules will still apply for any service that a provider wants to bill to Medicaid. She said each community she has talked to seems to have a very different idea of what will work for them.

Betty King volunteered to join the committee to provide input on peer involvement. She will participate in the next scheduled meetings.

Jack Willey noted that three of the committee members, he, Susan, and Chris, have terms that will be ending on April 30. It was the consensus of the group that if the committee's work on the rules is not completed by that date, they will continue to serve on the committee until the rules are completed to provide continuity. Jack, Susan, and Chris all expressed their willingness to do so.

Deb Schildroth asked if there was an update on rules for subacute care. Jim Friberg from the Department of Inspections and Appeals responded. He said DIA is working on them and have had assistance from a Drake Law School intern. They will go through the regular DIA rulemaking process. The number of publicly funded beds statewide is limited to fifty. Once the rules are written and approved, DHS is to release a Request for Proposals for bidders to provide the service.

LEGISLATIVE DISCUSSION

Teresa Bomhoff asked for a few minutes to present some advocacy information she had prepared. Teresa shared three handouts. She noted that the legislative priorities shared by the Iowa Mental Health Planning Council, NAMI (National Alliance on Mental Illness) of Greater Des Moines, and other organizations are similar to the legislative recommendations made by the Commission. She went over several sheets she identified as "next steps" for the MHDS system, including:

- Continuing equalization funding
- Suspending or repealing the "claw back" of county mental health dollars

- Continuing risk pool funding
- Supporting a Broadlawns plan to add 15-20 acute care inpatient beds, build a mental health clinic, and start a psychiatrist residency program
- Funding reduction of the HCBS Waiver waiting lists
- Supporting the creation of an Iowa Office of Suicide Prevention
- Opening a Mental Health Advocate's Office within a State agency
- Funding an acute care bed tracking system
- Enhancing mental health workforce capacity

Teresa's materials also included a list of mental health services and supports for adults and a similar list for youth, State legislative information on committee and reports, and a comparison of the Iowa Medicaid, Iowa Wellness, and Iowa Marketplace Choice Plans, including information on mental health and substance abuse services covered. Teresa also shared a handout titled "Four Legislative Needs," which she described as an in-depth analysis of the topics previously outlined, and a one-page "Dear Legislators" letter layout out the four key needs she believes should be addressed. She encouraged others to sign-on to the letter.

NEW APPOINTMENTS TO THE COMMISSION

Jack Willey announced the new gubernatorial appointments to the Commission who have been confirmed by the Senate. Their membership terms will begin May 1. They are:

- Thomas Bouska, DHS Service Area Manager for the Council Bluffs area, will fill the seat formerly held by Gary Lippe
- Marsha Edgington, Superintendent of the Woodward State Resource Center, will fill the seat formerly held by Zvia McCormick
- Kathryn Johnson, Associate Executive Director of community Based Recovery Services for the Abbe Center, will fill the seat currently held by Susan Koch-Seehase
- Geoffrey Lauer, Executive Director of the Brain Injury Alliance of Iowa, will fill the seat currently held by David Hudson
- Michael J. Polich, President of Hillflower Inc., will fill the seat currently held by Chris Hoffman
- Lynn Grobe has been re-appointed to a second term

The appointment of a new board of supervisors member to fill the seat currently held by Jack Willey is pending.

REGIONAL DEVELOPMENT DISCUSSION

Members of the Commission exchanged information about regional development in their areas of the state. Suzanne Watson said her region is focused on getting individual and family input and writing their management plan.

Jack Willey asked how others were handling liability for the administrative aspects of the region. Deb Schildroth responded that her region is looking at taking out its own liability insurance for the region, which would be part of the overall administrative expense. Jack said that his region includes five county attorneys and they need to decide on who will provide legal counsel for the region. Deb said ISAC (Iowa State Association of Counties) came out with a statement that county attorneys could provide legal counsel for regions, but that some county attorneys feel differently because it could create conflicts of interest. She said her region is considering seeking outside counsel, which would be an added expense to the region. Suzanne Watson said that in her region they have one assistant county attorney available for routine matters; if something comes along that appears to be very time consuming or to be contentious among the counties, they may decide to hire outside counsel for those specific purposes.

Jack Willey asked how others are dealing with putting together RFPs and contracting for services. Deb Schildroth responded that her 10-county region has sent out contracts to providers in the region. The providers will be contracting with the region, not with individual counties in the region. She noted that they are not requiring the providers to all have the same unit cost for services because some are very rural and some are urban. She said they would like to have providers complete cost reports but are sensitive to the amount of cost reporting providers already have to do. They have one RFP out for supported employment services for the region, and it was developed by the administrative staff.

Lynn Grobe, Richard Crouch, and Suzanne Watson noted that they are all in the same 9-county region. Suzanne said that they have one contract for all providers, although the rates may not be the same the first year. She said they do not have any RFPs for services they are seeking at this time.

Jack Willey said his region is finding it challenging to deal with urban and rural areas and create something that will fit everyone's needs. Suzanne said she sees this as an ongoing transition process that will not be all done by July 1. She said they would be more focused on services and contracts after the management plan is done.

Chris Hoffman asked if regions had a plan for what they would do about people who do not sign up for the Iowa Health and Wellness Plan. Deb Schildroth said her region has been coordinating efforts between community mental health centers (CMHCs) and county offices to help get people signed up, but they have told mental health centers that they will not go unpaid if they provide services to people who have not signed up for coverage. There may come a time that if a few people just refuse to cooperate, the regional funding will stop, but every effort will be made to avoid having people fall through the cracks or providers go unpaid.

Chris Hoffman and Patrick Schmitz both said that their agency policy is to serve everyone who comes to them, regardless of ability to pay. Patrick said that means either that they serve those who are unfunded or be prepared to take the blame for not taking care of them. He said CMHCs need some mechanism to make sure they can

continue to offer the services people need because that is their mandate. Deb noted that there are also people who have signed up for insurance coverage, yet continue to need assistance because they cannot afford the copays or deductibles. Chris Hoffman commented that some people are convinced that all they have to do is show up at a provider's door and they will be served. He said his concern is that if CMHCs turn them away and there is a violent act, a suicide, or some other adverse incident, the CMHC will be considered liable.

Deb Schildroth noted that if the person is eligible for some other type of coverage or funding, the legislation says that source of funding must be pursued first. She said that her region's stance is that as long as there is a good faith effort, they will continue to fund the person and support the process of getting them access to any other benefits available. She said there are also cases where Medicaid coverage lapses for a period of time and the region may fill the gap.

Jim Rixner commented that what has been discussed is "business as usual" for CMHCs, because they routinely deal with people who are non-compliant and do not follow through with these kinds of expectations. He said it is the responsibility of the CMHCs to educate clients and help them see that it is in their best interest to sign up for insurance coverage and the make use of the benefits it will provide them.

Suzanne Watson said that the counties in her region were asked by CMHCs to send out notices of decision (NODs) that county funding would be discontinued on April 30 as a way of getting people to take notice and sign up for the IHAWP. She said they would continue to fund individuals when necessary, but also need to get people to start taking some responsibility for their own care.

Deb Schildroth said she thinks it is important to consider that the people who were on Iowa Cares were on it primarily to get medical services because it did not really cover mental health care, so those people so those people who are now enrolled in IHAWP are not reducing mental health costs to counties. She said it is still a confusing system, especially for people who have not had health insurance coverage.

Suzanne Watson said counties are really funding a low percentage of people served at CMHCs. In her area, only about 14%, yet the centers seem to be very reliant on the county funding they have been receiving. Patrick Schmitz responded that counties have been the safety net funding piece that has allowed CMHCs to keep going because they are typically the one sources that pays CMHCs what the services cost. Suzanne said that there is a discrepancy in rates. Counties are paying providers a lot more than private insurance or Medicaid is paying; there is a need for insurance reimbursement rates to be more reasonable. Chris Hoffman said that the cost-reporting bill, HF 2330 is intended to address that. He says he has concerns about the quality of services provided by those who will take contracts for very low amounts.

Jack Willey asked if the CMHCs see many clients who do not have a family member or someone else supporting them and helping them get the services they need. Jim

Rixner responded that Siouxland Mental Health serves about 4000 people and about 25% of them have a family member to provide supports, and another 25% receive supports through integrated health homes or other care coordination services. Sharon Lambert commented that it gets frustrating for individuals and family members who do not know how to navigate the system or are easily discouraged by filling out forms, and it can be easy for them to give up if they do not have support through that process. Chris Hoffman said that his agency operates an 18-bed residential treatment unit and at least half of the people who come there, are not signed up for anything, more than 80% come in on some kind of psychiatric medication, some are not very literate, and at best, half will have any kind of support person with them.

Jim Rixner commented that historically people with mental illness have not had insurance coverage, and counties needed to take responsibility for providing or funding services. He said that now they may have coverage but the reimbursement rates from insurance companies for the marketplace plans are very low and counties are facing the "claw back," which could have a far-ranging effect. He said it is impossible to predict how counties and regions will be faring by July 1, 2015.

Teresa Bomhoff commented that she has been in contact with the Insurance Commissioner, and has been told they will not look at reimbursement rates, but they will look at the adequacy of the provider network for an insurance carrier and will remove plans that do not have adequate networks. Patrick Schmitz noted that it is important to know what they consider adequate and what standard or definition they use. Chris Hoffman said that it would also be important to know if they only look at primary health care services, or if the adequacy of behavioral health care is considered. Deb Schildroth suggested that the regions might have a role in finding creative ways to support CMHCs until there is a longer-term solution.

PUBLIC COMMENT

No public comment was offered.

Theresa Armstrong announced that Rick Shults would be unable to leave the Capitol to attend the Commission's afternoon session. It was the consensus of the group to forego a lunch break, continue with the remaining agenda items, and adjourn early.

SAME DAY MENTAL HEALTH SERVICES

Patrick Schmitz shared information about an initiative that a group of community mental health centers have participated in to change the way they do business and build the capacity to start providing mental health services the same day people present seeking them. The mental health centers participating in the initiative are: Plains Area MH Center, Abbe Center for Community MH, Black Hawk-Grundy MH Center, MH Center of North Iowa, and CMHC of Mideastern Iowa. They are all members of the Iowa Association of Community Providers (IACP) and their connections with the National Council for Behavioral Health allowed them to write for a collaborative grant that

provided access to a team of consultants to help them readjust and readapt their business practices. Patrick said it was an eight-month process and each CMHC met with their individual consultants each month during the process. There was enough flexibility for each organization to define what areas they wanted to work on, but they also had common areas:

- Adequacy of capacity - meaning the ability to get folks in to see a clinician in a time manner; recognizing that for some clients waiting four weeks for an appointment is an eternity and may mean that person simply does not get the services he or she needs

- Documentation - finding the best balance of meeting meet compliance and insurance documentation needs without gathering too much information or placing a burden on the clients, and reducing duplication of information

- Consumer engagement and outcomes – learning how to help clients feel better and be more comfortable with the process; increasing their understanding and participation in achieving outcomes

- Compliance with national standards – including documentation, access, levels of care, and episodes of care; within a level of care is an episode of care that defines where you are, for how long, and what will be going on at that stage (used in the substance abuse treatment world)

- Increasing revenue – reducing no-shows, making the best use of clinician time, and expecting clients to pay their co-pays

- Data-based decision making – doing a better job of making decisions based on data and using data to direct what you do as a provider

Patrick said they needed support from DHS and Magellan because they were asking to break the rules to a certain degree and adjust a few things from the standards in terms of the amount of data they were collecting. Each center developed its own goals with their consultants. They used a rapid cycle change process, utilizing a series of steps in about a 30-day process:

- Look at the problem
- Devise a solution
- Implement the solution
- Evaluate how it is working
- Make adjustments
- Keep improving and moving closer to what is best

Patrick said they reviewed their intake process, looking at how much time (both staff and client time) it takes to get a person into the system, and how they could make the process simpler and faster. They used to mail out a big packet for clients to fill out and

return and now they just gather a few pieces of basic information over the phone. Patrick said that in some centers, a person can walk in at any time of the day and be served. He said Plains Area MH Center is not quite there yet, but they are getting closer. They can usually offer a therapy appoint the same day or the next day. When people call, they are now often commenting that they did not expect to get in so fast. He said they are also increasing their capacity by adding two full time psychiatric practitioners by June.

Patrick said they have gotten rid of intake forms and things that were not adding clinical value. They are teaching staff how to handle phone calls better by using a standard process and scripting. They are working to improve customer service and trying to keep from having no-shows for appointments. They used to make reminder phone calls 24 hours in advance of an appointment. Now they make the calls 48 hours in advance, which allows time to backfill appointments that are cancelled and means less downtime for the therapist. He said they are thinking more like a business and know they cannot afford to "give away a free set of tires with an oil change." He said they recognize they need to do certain things to take care of themselves, their clients, and their business.

Scheduling of appointments now happens at the front office, not by the therapist. Patrick said that therapists tend to be "pulled in" and overextend themselves when scheduling, while people at the front desk can more objectively work from the available openings. Patrick said they have moved to collecting copays at the beginning of the session, which helps to create the expectation that people will make the payment from the beginning of the first appointment. They have significantly cut down the amount of documents that have to be completed and changed how therapists do their documentation. They used to do it at end of session, the end of day, or the end of week, and when it builds up over time it tends to be less complete and less accurate. They have moved to concurrent documentation, which means it must be done by the end of day.

Therapists also use collaborative documentation. That means the client is involved in documenting the appointment. The therapist types into the electronic health record or dictates notes while the client is still there. Errors or misunderstandings in directions to the client can be caught immediately and corrected. The client has an opportunity to ask any questions. Clients are a part of it. The client knows and approves what is said about them, can offer their own input, and has the information they need to do their own "homework" before the next appointment. Everything happens while it is fresh in their minds, and the work is done when the client leaves the appointment. It can be challenging to use language that is consumer friendly and meets insurance documentation requirements, but that is the goal. About 90% of clients say they like the collaborative documentation.

Patrick said that anyone coming into his agency now is required to spend about 12 hours listening to webinars to learn how to make the concurrent and collaborative documentation model work. It allows for good interaction and even some negotiation between the client and the therapist. Patrick said they are seeing it result in better

communication and understanding. It also allows more patients to be scheduled and increases capacity with the same number of therapists.

Patrick said one of the next big steps is level of care and episode of care, which involves evaluating clients when they come in to determine where they are and where they need to be, then creating a clear plan and explaining to the client what they can expect. Productivity standards are important. Documentation is expected by the end of the day. This also helps protect the agency, by ensuring that records are complete and up to date. It also helps with compliance for insurance. Patrick said that their system does not allow a billing to go out without the notes being done. Previously with hand-written notes, that could happen.

Chris Hoffman asked how they handled documentation for group therapy. Patrick responded that his CMHC is not doing any group therapy currently, but they would expect the therapist to do some documentation with the group and then built in some follow-up time to finish the documentation after the group session.

Patrick said they have developed a “no-show” policy to manage appointments. If a client has two consecutive no-shows or three over the course of three months, they are contacted to talk about what is preventing them from keeping appointments and if they are ready to continue therapy at this point. Jim Rixner commented that his center refers “no-shows” to a no-show therapy group and tries to use that as a teaching opportunity. Some of the CMHCs do only walk-in intakes. Patrick says Plains Area MC Center schedules intakes one or two days in advance. They are still working on better integration with primary care and Patrick says he believes integrated health homes will help with that.

Iowa was one of 14 states who received consultation through these collaborative grants. Patrick said a longer process would have been valuable because there is a lot more that could be done. The consultation was provided by MTM Services, and they will contract with agencies directly for their clinical and business consulting services.

Rebecca Peterson asked Patrick if they were seeing more clients coming in for quicker access. Patrick responded that he had not seen a lot, but that this new model is making them more competitive, has reduced paperwork, and made it easier for clients to get in for services. He said it has made them more responsive to their clients and more attractive as a service provider. Rebecca commented that her agency has walk-in assessments for substance abuse, but the mental health services side has always taken more time.

Betty King complimented Patrick on sharing what this group of centers have been doing and expressing complex ideas in a way that everyone can understand.

Chris Hoffman commented that what Patrick described is a culture change that is harder to make than it sounds. Patrick said they have had some staff people leave because they just did not think this was something they could do, but they have decided that this

is how they want to move forward as a CMHC. He said they are about 16 months into it and expect it will take another one to two years to get everything working the way they have envisioned.

NEXT MEETING

The next meeting is scheduled for Thursday, April 20, 2014, at Polk County River Place in Des Moines. Chris Hoffman suggested inviting the new director of the Office of Consumer Affairs to meet the Commission and present an update on OCA activities.

Deb Schildroth said she would like to talk about outcomes and the expectations for regions, including what kinds of outcomes they should be tracking as they move forward.

The meeting was adjourned at 12:15 p.m.

Minutes respectfully submitted by Connie B. Fanselow.